Provider Inquiry Form

Provider Number:

Provider Name and Address:

Telephone # ( ) ext.

Date of Inquiry:

Contact Person:

If this inquiry is about a member, please include the information requested below. Don't forget to indicate if the data was taken from an RA (Remittance Advice) or a claim.

Member Name: Last First Initial

Member ID Number:

Date of service:

Date of RA:

Data taken from: (Check one) ☐ RA ☐ Claim

Trans Control Number from RA:

INSTRUCTIONS:

* Use one form per inquiry.
* Select the appropriate box below for completion.

A. Medical Review Claim Inquiry.

B. Non-Medical Review Claim Inquiry. Use this box when you want to inquire about the status of a claim submitted to GHP.

C. Prior Authorization Inquiry. Use this box when you receive a denial because you did not obtain a prior authorization. Please include supporting medical documentation.

D. General Inquiry.

A MEDICAL REVIEW CLAIM INQUIRY

State the nature of your inquiry. Be as specific as possible.
Please include a copy of your remittance advice as appropriate.

Fax Form to: 866-483-1044

Mail form to: Georgia Health Partnership
Medical Review
PO Box 5000
McRae, GA 31055-5000

C PRIOR AUTHORIZATION INQUIRY

State the nature of your inquiry. Be as specific as possible.

Fax Form to: 866-483-1044

Mail form to: Georgia Health Partnership
Medical Review
PO Box 7000
McRae, GA 31055-7000

B NON-MEDICAL CLAIM INQUIRY

State the nature of your inquiry. Be as specific as possible.
Please include a copy of your remittance advice as appropriate.

Fax Form to: 866-483-1044

Mail form to: Georgia Health Partnership
Provider Inquiry
PO Box 5000
McRae, GA 31055-5000

D GENERAL INQUIRY

State the nature of your inquiry. Be as specific as possible.

Fax Form to: 866-483-1044

Mail form to: Georgia Health Partnership
Provider Inquiry
PO Box 5000
McRae, GA 31055-5000